BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

ROGER LEE JOHNSON Claimant	)	
VS.	)	Docket No. 1,038,509
LABOR READY CENTRAL, INC. Self-Insured Respondent	)	

ORDER

STATEMENT OF THE CASE

Respondent requested review of the August 14, 2009, Award entered by Administrative Law Judge John D. Clark. The Board heard oral argument on November 20, 2009. Phillip R. Fields, of Wichita, Kansas, appeared for claimant. Vincent A. Burnett, of Wichita, Kansas, appeared for the self-insured respondent.

The Administrative Law Judge (ALJ) found that claimant's methicillin-resistant *staphylococcus aureus* (MRSA), his bilateral hearing loss, and the necessary medical treatment during his hospitalization are all the direct and natural result of his work-related fall of December 12, 2007. Further, the ALJ found that claimant is permanently totally disabled and is entitled to compensation based on an average weekly wage of $366.41.

The Board has considered the record and adopted the stipulations listed in the Award, including claimant's Exhibit 1 to the preliminary hearing, which was admitted by agreement at the regular hearing, and the Stipulation relating to wage records filed with the Division on September 18, 2008.

ISSUES

Respondent argues that claimant failed to prove that his fall of December 12, 2007, caused, aggravated or accelerated his MRSA. Respondent further contends there is no evidence in the record that claimant's bilateral hearing loss was caused or contributed to by claimant's work-related fall or by his MRSA condition or its treatment. Further, respondent argues that claimant's MRSA condition arose out of a personal risk, *i.e.*, his use of cocaine, both intravenously and by "snorting." If the Board finds that claimant's MRSA condition was aggravated or accelerated by his accident of December 12, 2007, respondent contends the aggravation or acceleration was temporary in nature and was not a factor in claimant's current permanent impairment or disability. Respondent argues that

claimant is not presumptively permanently, totally disabled. In its application for review, respondent listed as an issue claimant's average weekly wage, but that issue was not discussed in its brief to the Board. During oral argument to the Board, respondent alleged that claimant's preinjury gross average weekly wage was $278.06. Finally, respondent argues that claimant's supplemental answers to interrogatories Nos. 13 and 19, filed June 19, 2009, after the expiration of claimant's termination date and without a stipulation by the parties, should not be made a part of the record. In its reply brief, respondent argues that neither K.S.A. 2008 Supp. 44-501(a) nor K.S.A. 2008 Supp. 44-508(e) provide benefits for non-work related conditions that are aggravated, accelerated or intensified by a work accident.

Claimant argues that claimant's work-related injury aggravated, intensified or accelerated his MRSA condition and, accordingly, the ALJ's finding that he is permanently, totally disabled as a result of his December 12, 2007, work-related injury should be affirmed. Claimant further contends the ALJ's orders for payment of claimant's past medical expenses, unauthorized medical, and right to claim future medical upon application were also appropriate and should be affirmed. Claimant further contends that his supplemental answers to interrogatories should be admitted as part of the record because the interrogatories submitted to him required him to supplement his answers should additional information be received.

The issues for the Board's review are:

(1) Did claimant suffer personal injury by accident that arose out of and in the course of his employment?

(2) If so, what is the nature and extent of claimant's disability?

(3) Is claimant entitled to payment of his medical expenses, unauthorized medical and future medical upon proper application?

(4) Should claimant's supplemental answers to Interrogatories Nos. 13 and 19 be included in the record in this case?

(5) What is claimant's pre-injury average weekly wage?

FINDINGS OF FACT

Claimant began working for respondent, a business that places temporary employees, in October 2007. On December 12, 2007, he was working at Bartlett Grain Elevator. His shift began at 7 a.m., and he was instructed to clean up some wet grain. In doing so, he rode a man lift from the boot pit to the main floor. While trying to get off the

man lift, his right boot caught on the ledge and he fell, landing on his head.[1] The man lift then came back down onto his head and chest. After the accident, paramedics were called, but claimant did not seek further medical treatment and went back to work, finishing a 16-hour shift. After work, he went home and, after three hours of sleep, woke up in pain. He states that he thought he had pulled some muscles so he called in. He said he stayed in his recliner chair until Saturday, three days after the accident, when he succumbed to his cocaine addiction in an effort to relieve his pain.

On Monday, December 18, 2007, claimant called respondent to say he was going to the hospital. He was taken to the emergency room at Wesley Medical Center by ambulance. He was suffering from sepsis, renal failure and respiratory failure. He was found to have community acquired methicillin-resistant *staphylococcus aureus* (CA-MRSA) bacteremia and had a golf-ball size abscess on his right buttock that contained the MRSA bacteria. The CA-MRSA spread to various areas of his body, including his cervical spine, his psoas muscle and his abdominal cavity. He was treated with intravenous antibiotic drugs and surgeries. He was in the hospital a total of 43 days.

Claimant said he was completely healthy before his accident.[2] He was able to work full time in a physically strenuous job, whereas now he has limited use of his legs, arms and hands. He cannot stand for longer than 10 minutes at a time and cannot walk without a walker. He has limited mobility in his neck. He is in constant pain in his neck, arms, hands, and legs. He has lost 100 percent of the hearing in both ears. He also has memory loss.

Claimant admits that he has been addicted to cocaine for as long as 20 years and that he both smoked and snorted cocaine.[3] He also suffers from Hepatitis B and Hepatitis C, both of which are common diseases in cocaine users. He claims he was "clean" several months before the accident occurred.[4] However, after his accident claimant resumed using cocaine.

While hospitalized, claimant was seen in consultation by Dr. Thomas Moore, who is board certified in internal medicine with a specialty in infectious diseases. Dr. Moore has restricted his practice to infectious disease cases since 1996 and is on the infection control committee of all four major hospitals in Wichita. His report of August 1, 2008, states that in his opinion, claimant developed bacteremia spontaneously and that he was in septic

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[1] In claimant's answers to interrogatories, he did not say how far he fell, but either he or his wife told Dr. Chris Fevurly on May 16, 2008, that he fell a distance of 20 to 30 feet, landing on his head and left side.

[2] P.H. Trans., Cl. Ex. 1, Answer to Interrogatory No. 17.

[3] Claimant's wife told Dr. Fevurly that claimant at times injected cocaine intravenously.

[4] P.H. Trans., Cl. Ex. 1, Claimant's answer to Interrogatory No. 15.

shock when he entered the hospital on December 18, 2007. He had an abscess on his right buttock that contained MRSA, and the staph infection had also gotten into his bloodstream. Dr. Moore said the MRSA was not a natural and probable consequence of claimant's fall, and he was reasonably certain the MRSA in claimant's right buttock abscess was present before the December 12, 2007, accident. Further, Dr. Moore said claimant's development of sepsis had no relationship to claimant's fall.

Nine days into claimant's hospitalization, on or about December 27, 2007, he was found to have an enlarged left iliopsoas muscle. A CT scan was performed, but there was no evidence of fluid collection or abscess in the muscle at that time. A CT scan done on January 7, 2008, however, showed that since December 27, abscesses had developed in several places, including claimant's left abdomen, pelvis, hip and psoas muscle. Dr. Moore said that sometime between December 27, 2007, and January 7, 2008, claimant's injured psoas muscle was seeded with MRSA, and he developed tropical pyomyositis.

In his August 1, 2008, report, Dr. Moore stated:

> In my opinion, the buttock abscess due to CA-MRSA was not related to Mr. Johnson's employment. I cannot say with any degree of medical certainty that Mr. Johnson's presentation in December 2007 for sepsis was related to his employment, but I can say to a reasonable degree of medical certainty that the patient's muscle injuries which were sustained on the job, provided fertile ground for the CA-MRSA to take root and blossom, thus significantly complicating his hospitalization and medical care.[5]

Dr. Moore said that if claimant had fallen 20 feet, he would have expected claimant to have some bruising or edema upon admission to the hospital on December 18. He had no explanation for the fact that neither the emergency room records nor the EMS records showed that claimant had any sign of hematoma or bruising. However, he also said that a person can sustain injury to a muscle and not have external signs on physical examination.

Dr. Moore said that "because muscle is difficult to infect experimentally, it was always presumed that there must be some subclinical injury to the muscle that allows for the seeding of the muscle by bacteria."[6] He admitted that it is well documented that patients often have no memory of any antecedent injury. However, "the presumption is that there is–there must be some injury to the muscle and that explains why the infection takes root in the muscle."[7] Therefore, Dr. Moore assumed that for the MRSA to have

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[5] Moore Depo. (Oct. 20, 2008), Ex. 2 at 2.

[6] Moore Depo. (June 23, 2009) at 8.

[7] *Id.*

caused pyomyositis to develop in claimant's psoas muscle, there had to have been an injury to that area. He further stated that more likely than not, if the circumstances of the fall were accurately described, the fall caused the injury that allowed the seeding of the psoas muscle with MRSA. However, when asked if the psoas muscle was the only area seeded with MRSA because of trauma, Dr. Moore stated: "I'd say the psoas muscle is one which is debatable, but the . . . tensor fascia lata and other muscles in the left thigh are all–were almost certainly, in my opinion to a reasonable degree of medical certainty, seeded by the staph . . . that the staph took root in those muscles because of the prior injury."[8]

Respondent introduced several reports from medical journals referring to abscesses in the psoas muscle. One of them, a report in the American Journal of Emergency Medicine, stated: "Primary iliopsoas abscess is typically caused by hematogenous spread of *Staphylococcus aureus*."[9] In commenting on this statement, Dr. Moore said:

> [T]he prevailing wisdom is that there's a presumption that somehow the staph gets into the muscle. It's not really clear why. But it's not proven and obviously, you know, as with other cases of pyomyositis, even those without staph aureus, it will develop in the muscle without any antecedent history of trauma.[10]

Dr. Moore said that claimant also had MRSA in his cervical spine, and a laminectomy was performed to remove the epidural abscess.[11] In his August 1, 2008, report, Dr. Moore said he believed the abscess in claimant's cervical spine were related to claimant's fall.

> It is my opinion that the cervical epidural abscess falls into the same category as tropical pyomyositis. This is an unusual complication of bacteremia and one has to assume that some cervical spine injury also played a role in the development of this problem.[12]

In his deposition testimony, however, Dr. Moore said that the cervical spine abscess could have occurred with no prior injury but just from the bacteria getting into claimant's bloodstream and seeding the disc space. He said the abscess in the cervical spine was sufficiently geographically distinct from the psoas abscess so that the two would have to

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[8] *Id.* at 46-47.

[9] *Id.*, Ex. 5 at 1.

[10] *Id.* at 26.

[11] The record does not reveal when this surgery was performed.

[12] Moore Depo. (Oct. 20, 2008), Ex. 2 at 2.

be independent seeding events and the cervical abscess was caused by the spread of the MRSA through the bloodstream independent of the trauma.[13]

Dr. Moore said he did not believe that claimant's fall accelerated the progression of the MRSA bacteria in his system. He also said that bacteremia or staph aureus always results in a clinical condition, such as sepsis, that requires medical care, and the fact that claimant had staph aureus in his blood is something he would have been admitted to the hospital for eventually. However, he said most patients who develop staph bacteremia do not develop pyomyositis, and when pyomyositis occurs, the muscle needs to be opened and drained surgically. In his initial report and at the time of his first deposition, Dr. Moore believed that the claimant's surgeries performed for the purposes of draining the abscesses in his psoas muscle and his thigh muscles were the result of claimant's fall. However, at his second deposition, Dr. Moore acknowledged that the MRSA can spread to the muscle from the blood even without trauma.

> Q. [by respondent's attorney] –it talks about the anatomy of the psoas muscle makes it susceptible to infection by direct extension and distant seeding. The rich venous blood supply from the adjacent lumbar spine and the lymphatic channels overlying the muscle lead to bacteremic spread through the hematogenous route. That suggests to us that, again, without trauma you can have muscle tissue invaded by MRSA or seeded by MRSA in that location without direct trauma. Would you agree with that or not?
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> A. [by Dr. Moore] I think–no, I think their characterization is correct, yes, that the psoas muscle can be infected either through direct spread or hematogenously.
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> . . . .
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> Q. I guess what I need to explore is you referenced the word presumed earlier. Are you of the opinion that a MRSA infection can seed in the psoas muscle tissue without trauma to that area?
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> A. Yes. That is true. Staph infections can definitely seed into muscles, as I say, when there's no recollection of any known injury. That is certainly true.[14]

In addition, because the infection persisted in the bloodstream, Dr. Moore said this suggests claimant had an infected blood clot which could have been the result of injection drug use.[15] Ultimately, Dr. Moore said that the trauma could have contributed to the

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[13] Moore Depo. (June 23, 2009) at 39.

[14] *Id.* at 10-11.

[15] *Id.* at 17.

development of the infection in the psoas muscle or that it could have developed without any prior history of trauma.[16]

During his hospitalization, claimant sustained bilateral hearing loss. Dr. Moore said he could not say for certain what caused claimant's hearing loss. He said it was not caused by fractured bones because it was bilateral. Rather, he said it was true nerve damage to the auditory nerve and that was "almost always going to be due to medication . . . ."[17] He did not know which specific medication caused the hearing loss but felt that either Daptomycin or Gentamicin was the likely culprit.

Dr. Moore said he could not make a full estimation of the extent and permanency of claimant's injuries. He said in the vast majority of cases, pyomyositis is a curable condition–that the majority of patients have their muscles drained and the sequelae are limited. The condition is temporary because it is curable with treatment and the location where the condition seeded in the body was not determinative either of the need for medical treatment or the temporary nature of the condition.

> Q. [by respondent's attorney] All right. Regardless of the fall then and where the MRSA ultimately seeded in the psoas muscle, would he have required the medical treatment that he received?
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> A. [by Dr. Moore] I see. I see. Right, I'm sorry, I see what you're saying. Yeah, I think it's fair to say that this was–the fact that he had bacteremia or the staph aureus, that always results in some injury to tissues or a clinical condition like sepsis that requires medical care. So my point about that is that the fact that he had staph aureus in his blood, which is not related to the injury in my opinion, which is something that–I'm sorry, not really of the fall, is something he would have been admitted to the hospital eventually for anyway.
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> Q. I know you haven't seen him since March of '08 and we actually took your deposition earlier, but do you have an opinion as to whether or not Mr. Johnson should have recovered from the MRSA infection based upon the treatment that you provided?
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> A. Well, yes, I can't make a full estimation of the severity–I mean, of the extent and permanency of his injuries, but in the vast majority of pyomyositis it's a curable condition. The majority of patients have their muscles drained and they move on. The sequelae are limited.[18]

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[16] *Id.* at 41.

[17] Moore Depo. (Oct. 20, 2008) at 24.

[18] Moore Depo. (June 23, 2009) at 35-36.

Dr. Moore did not remember claimant having anything, other than deafness, that was going to be permanent. He said that claimant's deafness was likely caused by the medication prescribed for the MRSA and that claimant would have gotten that medication regardless of how the staph got into his body.

Dr. Chris Fevurly is board certified in internal medicine and preventative medicine/occupational medicine. At the request of respondent, Dr. Fevurly performed an independent medical examination of claimant on May 17, 2008. Dr. Fevurly said that Dr. Moore was more expert than he in infectious disease, but less expert than he in regard to causation analysis in epidemiology, the review of risk factors in association with disease causation.

Because claimant is deaf, his wife came with him to the examination, and Dr. Fevurly said that 90 percent of the information he received came from claimant's wife. Dr. Fevurly was given a history that claimant fell some 20 feet, after which he was able to finish the remainder of his shift performing physically demanding work. Dr. Fevurly stated that he did not think it was possible to fall 20 feet and not suffer some sort of orthopedic injury. Nor did he think anyone could fall from 20 feet and then finish out a workday. He especially did not think claimant could have fallen that distance, landed on his head, and not suffer significant head trauma or some type of fracture. Therefore, he did not think that claimant fell 20 feet. Dr. Fevurly did not have all of claimant's hospital records to review, but the hospital records Dr. Fevurly reviewed included a CT head scan and a CT cervical spine taken on claimant's admission, neither of which showed an acute fracture. The hospital records did not describe any bony injuries, any soft tissue swelling or any description of bruising.

When claimant was admitted into the hospital on December 18, 2007, he was near death. He was in septic shock and was experiencing renal and respiratory failure. Claimant's hospital admission records revealed he had a 2 x 3 centimeter abscess on his right buttock. A culture of the abscess showed it was MRSA. Dr. Fevurly said that based on the size of the abscess on claimant's right buttock, the abscess had to have been there for at least a week. Dr. Fevurly could not explain how claimant got the right buttock abscess but said that claimant was not the healthiest man and already had hepatitis B and C and, although claimant denied ongoing drug use, that was proven not to be true by a positive drug screen on admission.

Dr. Fevurly said it could not be said with any degree of medical certainty that claimant's fall had any clinical connection to the development of his MRSA bacteremia. When claimant was admitted into the hospital, he had oral herpes simplex of his lips, which Dr. Fevurly said could be a possible source of entry for MRSA. Also, Dr. Fevurly said that people who use cocaine are at a much higher proportion or incidence of having staph aureus colonization in their nose because they snort cocaine, causing a disruption in the mucosal membranes of the nose. Dr. Fevurly said: "I think that [claimant] either got the

MRSA from his cocaine usage or he got the MRSA from the abscess in his right buttocks and it got into his bloodstream . . . ."[19]

Dr. Fevurly said that once staph bacteria gets into one's bloodstream, it is very sticky and will latch onto any solid surface. Dr. Fevurly disagreed with Dr. Moore's theory that there must be damaged muscle tissue for MRSA to seed. Dr. Fevurly said that the bacteria will go where it wants to go and will grow wherever it chooses, and Dr. Moore's theory that there has to be traumatized tissue does not coincide with what went on with claimant. Dr. Fevurly said he would not argue that if there is trauma to a muscle with a hematoma, it would more likely become seeded with staph aureus. But, he said, there is no evidence that claimant's psoas muscle was actually traumatized. Dr. Fevurly said that if claimant bruised his psoas muscle, which is a very deep muscle, he would have had some bruising on the skin in the subcutaneous tissue overlying that. He said that one cannot bruise a structure that deep inside the body and not bruise what is outside if the force comes from outside.[20]

Dr. Fevurly said that an MRI of claimant's cervical spine revealed epidural abscesses in and around the cervical spinal cord.[21] Dr. Fevurly said that once claimant had MRSA in his bloodstream, the sticky MRSA traveled and grew wherever it wanted. The MRSA can go into the bone, into the epidural space, into any distal or proximal organ, or into the muscle system. He said there was no evidence that claimant had significant trauma to his cervical spine.

Dr. Fevurly did not believe that claimant is employable. He said claimant has a significant problem neurologically now. Also claimant is now unable to hear effectively. Dr. Fevurly said that claimant's hearing loss could have been from the antibiotics or by his hypotensive state causing some type of neurological consequence to his hearing, but most likely the antibiotics. He was not sure why claimant is having so much trouble with his ambulation and suspects it is a combination of brain effects from the sepsis and potential spinal cord effects from the abscess that occurred there. However, Dr. Fevurly does not think claimant's unemployability is related to his alleged fall in December 2007 because claimant's outcome was not changed, accelerated, aggravated or contributed to by where the MRSA decided to seed. Dr. Fevurly said it would not have mattered whether claimant had a MRSA infection develop in the epidural space in his cervical spine, the psoas muscle or the abdomen cavity in the net outcome of his medical condition, as long as those areas were drained appropriately. He believes claimant's psoas muscle, spinal cord and intra-abdominal area have returned to their former status. Dr. Fevurly opined that claimant had a "complication neurologically from his sepsis, the fact that he was so hypotensive, had a

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[19] Fevurly Depo. at 34.

[20] This statement is contrary to Dr. Moore's deposition testimony.

[21] There is no indication in the record of when this MRI was done.

brain encephalopathy from that, due to his prolonged hypotensive state and then the complication of a hearing deficit from his antibiotic use."[22]

PRINCIPLES OF LAW

K.S.A. 2008 Supp. 44-501(a) states in part: "In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends."

K.S.A. 2008 Supp. 44-508(g) defines burden of proof as follows: "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record."

An employer is liable to pay compensation to an employee where the employee incurs personal injury by accident arising out of and in the course of employment.[23] Whether an accident arises out of and in the course of the worker's employment depends upon the facts peculiar to the particular case.[24]

The two phrases arising "out of" and "in the course of" employment, as used in the Kansas Workers Compensation Act, have separate and distinct meanings; they are conjunctive and each condition must exist before compensation is allowable.

> The phrase "out of" employment points to the cause or origin of the accident and requires some causal connection between the accidental injury and the employment. An injury arises "out of" employment when there is apparent to the rational mind, upon consideration of all the circumstances, a causal connection between the conditions under which the work is required to be performed and the resulting injury. Thus, an injury arises "out of" employment if it arises out of the nature, conditions, obligations, and incidents of the employment. The phrase "in the course of" employment relates to the time, place, and circumstances under which the accident occurred and means the injury happened while the worker was at work in the employer's service.[25]

It is well settled in this state that an accidental injury is compensable even where the accident only serves to aggravate or accelerate an existing disease or intensifies the

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[22] Fevurly Depo. at 43.

[23] K.S.A. 2008 Supp. 44-501(a).

[24] *Kindel v. Ferco Rental, Inc*., 258 Kan. 272, 278, 899 P.2d 1058 (1995).

[25] *Id.* at 278.

affliction.[26] The test is not whether the job-related activity or injury caused the condition but whether the job-related activity or injury aggravated or accelerated the condition.[27] This has even applied in instances where a work related accident caused an acceleration of a preexisting cancerous tumor.[28]

ANALYSIS

Claimant suffered no permanent physical injury in his December 12, 2007, fall at work. He already had the MRSA bacteria in his system before his accident at work on December 12, 2007. After considering all of the medical evidence and testimony, the Board finds that claimant's fall did not aggravate, intensify or accelerate his MRSA condition or his need for medical treatment. Its spread to various areas of his body was inevitable absent treatment. This spread was already taking place before the accident. Claimant's medical treatment and his ultimate impairments and disabilities, including his hearing loss, were all the result of a personal risk and disease process unrelated to his work accident.

Both Dr. Moore and Dr. Fevurly said the MRSA infection was already present and was not the result of claimant's fall. Also, claimant's development of sepsis had no relationship to claimant's fall. Claimant's need for medical treatment and hospitalization were due to his preexisting condition. He was admitted for sepsis, not the multiple abscesses that developed later during his hospital admission. It has not been established that the MRSA got into claimant's bloodstream because of the fall. The closer question is whether the fall caused injuries to the muscles that allowed the seeding of the MRSA in those areas. Dr. Fevurly says no. Dr. Moore initially advocated this causation theory, but by the time of his second deposition, except for the abscess in claimant's left thigh area, he appeared less confident of this opinion. He acknowledged that MRSA will seed in the muscle even without trauma. Ultimately, Dr. Moore said that claimant's fall did not accelerate the progression of the MRSA in his system. Claimant would have required the treatment he received regardless of the fall, with the possible exception of the surgeries performed for the purposes of draining the abscesses in the psoas and thigh muscles. So it is only that portion of the overall medical treatment that could be deemed work related. Nevertheless, those surgeries were for a curable condition which generally do not result in any permanent sequelae. Dr. Moore could not relate any of claimant's permanent

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[26] *Harris v. Cessna Aircraft Co.*, 9 Kan. App. 2d 334, 336, 678 P.2d 178 (1984); see *Demars v. Rickel Manufacturing Corporation*, 223 Kan. 374, 573 P.2d 1036 (1978); *Chinn v. Gay & Taylor, Inc.*, 219 Kan. 196, 547 P.2d 751 (1976).

[27] *Hanson v. Logan U.S.D. 326*, 28 Kan. App. 2d 92, Syl. ¶ 3, 11 P.3d 1184 (2000), *rev. denied* 270 Kan. 898 (2001); *Woodward v. Beech Aircraft Corp.*, 24 Kan. App. 2d 510, Syl. ¶ 2, 949 P.2d 1149 (1997).

[28] *Claphan v. Great Bend Manor*, 5 Kan. App. 2d 47, 611 P.2d 180, *rev. denied* 228 Kan. 806 (1980).

impairments or disabilities to the injury at work. Neither did Dr. Fevurly. When considering the record as a whole, the Board is not persuaded that claimant's injuries are work related.

CONCLUSION

Claimant has failed to prove it is more probably true than not true that his work-related accident aggravated, accelerated or intensified his preexisting MRSA condition or his need for medical treatment for that condition. In addition, claimant has failed to prove his accident at work on December 12, 2007, caused any permanent injury or disability. Based on the foregoing, the remaining issues are now moot.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge John D. Clark dated August 14, 2009, is reversed.

IT IS SO ORDERED.

Dated this _____ day of December, 2009.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

c: Phillip R. Fields, Attorney for Claimant
Vincent A. Burnett, Attorney for Self-Insured Respondent
John D. Clark, Administrative Law Judge